KanCare Educational Tour
Provider Questions and Answers
July 30-Aug. 2, 2012
Total Run Time: 59:00

Gary Haulmark—Topeka
First question, what if I don't sign a contract with an MCO? And this came up quite a bit. If you don't sign a contract with a specific MCO, you would be considered out of network provider. If I don't sign up with any MCO, can I still be a Medicaid provider? Yes you can. However, the services you provide may be limited to a very small Medicaid population or be considered, again, out of network by the MCOs.

Do all of the MCOs have to contract with me? Yes, the state requires each MCO to offer contracts to all existing providers.

What if an MCO doesn't pay my claim quickly? This has come up several times. The contract with the MCOs requires payment for all clean claims within 30 days. And this first year there's going to be uh, performance incentive payments so that those will be paid within 20 days.

What is a clean claim? Again, asked several times, and a good question. A clean claim means one that can be processed without obtaining additional information from the provider of the service or from a third party.

If a claim is denied by an MCO, can I bill fee-for-service Medicaid? No, is the answer.

What if an MCO wants to pay me less than what I was paid in the fee-for-service program? And that, that cannot happen. The MCO must pay you at least the fee-for-service rate that was offered in November, effective November 9th, this year.

Um, will there be training for providers about KanCare? Yes, there will be.

Um, will all three Os, will all three MCOs have the same prior authorization requirements? Each may have different requirements, but the state is requiring them to have transparent requirements so the providers will easily know what the requirements are. And I know they are working to standardize this as well.

Um, medical necessity requirements came up. All three states. All three states, all three MCOs, and this is important, like I said, it came up several times, was asked, all three must use the state definition outlined in attachment C of the KanCare RFP. By the long short of it is, the three MCOs must use the definition the state has been using.

Will providers who submit in-home service claims through AuthentiCare continue to do so? Yes, all three MCOs will be working with AuthentiCare.

I provide service to someone who self directs, what changes for me? You will continue to work with FMS agency and report your hours through AuthentiCare. So, nothing changes.

Um, another question that came up quite a bit, will each MCO have its own preferred drug list? No, the state will maintain the PDL.

Are, this one came up too, are MCOs incentivizing mail order pharmacy? No, although they are allowed to offer it as an option for members.

And another one that came up, will providers have any input into how KanCare operates? Yes, the MCOs have committees that will provide, will have provider representatives. I think you saw some of that in the provider presentations earlier from the three MCOs. Um, the Governor's KanCare Advisory Council is in place. And there are four external work groups that will help the state implement KanCare.

Alright, that's our FAQ. Let's see, questions. How will credentialing process work for individuals, individual providers CMHCs? There's going to be, it's in the works, there's going to be a single standard application that the three MCOs are working with our staff on at this time.

And you'll love, whoever asked this question, I'm sure you'll love my answer. When will the waiver be resubmitted to CMS? Very soon. (laughing)

When will the video be online? Next week. The slides that were up today from the MCOs, will also be online.

Um, will the state set the rate for nursing homes or will the facilities negotiate the rate with managed care companies? The state's going to set the floor, set the rate that's the floor. And then you can negotiate from there.

What happens if a provider does not contract with all three companies? Like we just talked about, it would be considered out of network services, if you are not contracted with a particular MCO.

Is the current dental…continued by the MCOs or still available? On dental, the current policy of of the dental services provided for children will continue. But as a value added service, all three of the MCOs are going to provide um, preventive dental services for adults. So, that will be expanding.

Can beneficiaries change plans during the year? Um, no. Just at the beginning of the year. Once a year, the beneficiaries will have the option to change plans.

Now, for some of these, I think this one I'm going to ask some of my uh, subject experts to come up. Lizz, do you mind? Lizz Phelps, are you in the room here? Lizz, has the state defined what is considered a clean claim when measuring the quality measure? Well, we just went over that. A clean claim means one that must be, can be processed without obtaining additional information.

Are providers going to be required to apply existing Medicare coverage guidelines, as well as policies developed by the MCOs?

Lizz Phelps—Topeka
That's another question about medical necessity. We're going to continue using the current definition, including those that are incorporated in the PAP, mental health and PIP substance use programs and that have been in regulation for years. No change in that.

Gary Haulmark—Topeka
Predicted cost savings be used in the waiting list for HCBS services?

Sec. Shawn Sullivan—Topeka
That's a hard question to answer. So, one of the things that we did not cover in the presentation was the anticipated savings through KanCare. As I mentioned on the very first, one of the first slides, our current Medicaid system is a $3 billion program and there have been about 7.5 percent cost increase per year. The savings that we projected through KanCare were initially about $850 million for five years. That was not cutting $850 million from a $3 billion program. It was reduce the, the growth per year from 7.4 percent to less than that by a percentage reduction. When the contracts were signed in late June, the last week of June, because of the discounts we now have locked into the current Medicaid program from each of the three vendors, the projected savings are now about $1 billion a year for five years. Again, that's not cutting $1 billion. It's reduction in growth of $1 billion. So, to directly answer the question, which is will the predicted cost savings be used to end the waiting list. For those of you who don't know, we currently have a waiting list for the Home and Community Based Services physically disabled waiver and also a waiting list for the intellectual and developmentally disabled waiver. Um, its current system with no changes, would be virtually impossible to reduce the waiting lists, when you're already spending seven to eight percent more a year. What we anticipate, as we move forward with KanCare, is that allows us to have more funds that appropriators, between the administration and the senate and the house will have globally available, to allocate to the Medicaid program. So, I'm not able to stand up here this afternoon and say "yes, all waiting lists are going to be gone in five years, three years." What we think, this gives us a better chance to reduce the waiting list over the next couple years by giving us more funds to allocate towards this.

Kelly Melton—Topeka
I'm Kelly Melton. I'm the pharmacy program manager at DHCF. And I'm a pharmacist. The first question is, how will pharmacists, pharmacy services be handled for nursing facilities? And for nursing facilities, which are primarily composed of Medicare Part D patients, I'd mention first of all, our MCOs have agreed to our current policy which is co-pay assistance on those claims. So, they will pick up whatever co-pay is left after Medicare Part D coverage has taken effect. For those pharmacies who do provide medication services to a nursing facility, we would strongly suggest you do contract with the MCOs that the nursing facilities will use also, be affiliated with, so that you will be able to submit pharmacy claims for those patients.

Um, why not Walgreens or Wal-Mart for prescriptions? Um, I think maybe there was some confusion about the slides that were presented. What we had listed are our three MCOs, as well as the pharmacy benefit managers that they will be affiliated with. And one of them, as you saw, was Amerigroup is affiliated with CVS Caremark. And they, CVS Caremark is an entity that processes pharmacy claims and helps with the administration of the pharmacy benefit for Amerigroup. It does not mean that your patients will only be able to receive a prescription from a CVS. Our pharmacy contacts at the MCOs have um, know that it's very important to us to contract with as many of our existing pharmacy providers as possible. And they have been given a list of our current pharmacy providers. So, the goal is to have as many current participating pharmacy providers as possible, contracted.

Um, how will billing be affected? Pharmacies will be able to bill their claims at the point of sale as they do with their other prescription claims. You know, as United mentioned earlier, some of them already have contracts with the existing PBMs that our MCOs work with, and so, there shouldn't be a lot that's affected in terms of that. They should just be able to continue to submit those claims through the pharmacy.

Um, will we have to switch pharmacies if we aren't using one listed on the slide? And again, I think that speaks to some of the confusion about the PBMs that were listed. Um, we are trying to contract as much of the pharmacy network as possible.

How can we get a copy of MAC drug list from the three MCOs? We asked our managed care organizations to provide a pricing lookup, where pharmacies can log in, type in the NDC of a medication and see what its current rate is. So, for those of you who are familiar with our current KMAP website, you can log on, type up the NDC and it will tell you, for example, if we do have a MAC pricing on a drug, it will tell you what that prescription is paying for. So, we have asked our MCOs to provide that functionality as well.

And, oh, will Medicaid clients get their medications from the MCO instead of their local pharmacy? Um, no. You will still receive medication services through your local pharmacy. And we are really excited about the opportunity to continue to work with our existing pharmacy providers.

Dave Halferty—Topeka
I'm Dave Halftery. I work with KDADS. And the question is, will nursing homes residents have to use the uh, PCP through the MCO or will they be able to maintain their current physician? So, as long as the, the system, the RFP and the contracts are set up to try and encourage all providers to enroll with all MCOs. If they choose not to though, there is a provision in there to pay, to require the MCOs to pay those providers that do not, the out of network providers. And I believe that's at 90 percent of the fee for service rate. So again, we tried to do as much as we could to encourage all providers to enroll in the networks with all of the MCOs, but if they choose not to, then there is a provision to cover that.

Gary Haulmark—Leavenworth
13:05
Will the application forms change? Does each MCO have a separate one? And I assume you're talking about um, um provider applications. And those will be standardized provider applications.

Um, will the credentialing process be equal across the three MCOs, so to decrease time for providers? And, yes, those will be standardized as well. Comprehensive.

Alright, will PDTBI, and there's three or four around this specific subject. Will PDTBI case management remain or will MCOs take over that case management. And basically, it's in the frequently asked questions. Um, if a, if a uh person is in the uh, disability waiver, if they're receiving disability, developmental disability services and they're receiving services from a CDO or from a community service provider, those folks will continue to provide case management services. The rest of the um, waiver services, the primary responsibility is with the MCO. And they will either directly or indirectly provide case management services. So, right now we're in conversations with the MCO about how that will look. And we should have more information on that in the next couple of weeks. But the bottom line is, outside of developmental disability services, the responsibility, again directly or indirectly, depending on how they want to handle it, is with the MCOs.

Um, can a case management agency be a provider for each MCO? Um, yes, they certainly could be is the answer.

Um, more about TCM.

Do you anticipate and expect providers will join all three plans? Yes, we anticipate. Yes, we hope so. We're encouraging all providers to join the three plans and we're encouraging the MCOs to sign up all current Medicaid providers.

Um, will payment rates for home health be negotiable or will they be the same across the state? I mean, there's a guaranteed floor, but everything is negotiable. It will be between the plan and the provider.

Um, will the MCOs be offering incentives for current providers to sign up with them? I know that the plans will have a variety of potential programs for providers. And some of those will be financial.

Will MRDD providers be included in this first wave of contracting or delayed until 2013? We will be doing a pilot project for MRDD. Um, those that are willing to participate in that will be fully integrated into KanCare. The other providers will be delayed a year on the long term supports and services side. all on the MRDD system, all physical health, all mental health will be integrated into KanCare. But, because of the delay implemented by the legislature, the long term supports and services piece that's provided by the CDDOs and community services providers will be delayed for a year.

What plan will be automatically be enrolled in? How is this determined?...There's auto enrollment. And the long and short of it is, auto enrolling will go through, and we'll use an algorithm. I hardly even know what an algorithm is. But again, the long and the short, we're going to look and see where the vast majority, which plan have the vast majority of, it's me, I'm being auto enrolled. Where are the vast majority of my providers? They're in plan, then Gary Haulmark will be enrolled in plan A. That's how it's going to work. We're going to look at your primary care provider, the other providers, and we're going to enroll you in the plan that has the vast majority of your providers. You can then change plans. You're auto enrolled. The beneficiary will have the opportunity to change those, to, to, to transfer, to move into either of the other two plans if they choose to do so.

For behavioral health, will the plans still include residential services? We're talking about PRTFs. The answer is yes.

Will CMHCs still be responsible for authorizing inpatient psychiatric care? The answer is yes.

Okay. Talking about the six measures to verify performance outcomes, how often will this be audited? Performance measures are going to be evaluated annually.

Okay, good question. Got a couple of these. When can providers expect to be getting contracts from the MCOs? Um, they touched on this, by October, the plans have to be, their networks need to be 90 percent filled out. So, over the next couple of months, you will be hearing from them, getting provider packets. I know from listening to the MCOs earlier today and yesterday and talking to some of them, in the next two to three weeks, they're expecting to get these provider packets out. But they have to be, they have to have the vast majority of their networks filled by October, and completely filled by November, I believe it is. So, you'll be hearing from them very soon.

Will KanCare pay for home health services? Yes.

Will Medicaid rates continue to change quarterly based on CMI? Will MCOs change their reimbursement rate to providers to correspond with each Medicaid quarterly rate? Yes, the state's going to continue to set quarterly rates for nursing facilities and these will be the floor for reimbursement.

Sec. Shawn Sullivan—Leavenworth
Second question, how can we save money by contracting with entities whose goal/purpose for existing is to make money for their shareholders? That really is an easy answer to the question, by aligning the financial outcomes that we expect from the state level, the outcomes we want to achieve with what the managed care entities are receiving through their capitated rate and performance goals and incentives.

Third, how will the dish payment be affected? Dish is a payment mechanism the hospitals, we are, KDHE is working with Kansas Hospital Association KHA on that and it's part of the negotiation in the 1115 waiver with CMS, so feel free to talk more about that with us later with KHA.

What does each provider must maintain a health information system mean? And if that's what I said in the slides, meant to say each contractor or each of the three MCOs is required to have an HIS.

Um, will we know who is on the MCOs advisory councils? How can we serve on these councils? I'm sure you can submit your names to the representatives in the back of the room. And yes, those will be public.

Why are the, why are there three managed care entities that you're contracting with and the answer for that is, looking at the successful experiences of other states, what's happened well, we wanted choice for consumers and we wanted competition between plans so we eventually landed on three on a statewide basis.

Um, how will the provider clearly know which MCO the member is with? They will have a card, you will know that as a provider and also you can call, if they don't have that card, if they come in for a dentist or physician appointment and you don't have that on file, there is a telephone number that can be called once we start this 866-305-5147. I'm sure you wrote that down real quick. You can talk to us afterwards.

What one site will medical providers go to verify KanCare eligibility and benefits? That will be much like it is now, through HP or intermediary through the KMAP site.

Is there an obligation on the part of providers to see all age populations or patients for dental oral surgery? That is a case where what is the situation on December 31st on current Medicaid will apply on January 1st to KanCare. So, that answer is, there is allowed for specialty clinics or be able to serve specialty populations, that will continue with KanCare.

Gary Haulmark—Fort Scott
Alright, will a comparison or summary of side-by-side MCO benefits and value added services be available? Um, the answer is yes. They will be available. Each contract the MCO sends to you will have that type of information. And the beneficiaries will get that information when they get their packets in November. You'll be able to see, the beneficiaries will be able to see the benefits and value added services in the plan they've been auto enrolled in and they'll be able to see the benefits and value added services in the other two plans so they can make a decision if they want to change plans.

Um, a couple of these, to be honest, I didn't quite get the meaning of the question, so I'm going to guess. And if I guess wrong, just grab me afterward if you would please. Will KMAP go away? And I think the KMAP questions are around eligibility. And the answer is no. So, you'll be able to look on KMAP for eligibility purposes.

Um, will we have to have, will there be three different billing systems? There's the potential for a single interface. There are discussions going on now about that. Quite honestly, hearing from some providers, they don't want a single interface, because that means four. Now, there are quite a few providers who are interested in a single interface. So, those discussions are ongoing and there's very much potential for a single interface.

Um, and there are lots of questions about this, clarify on HCBS clients, will they keep their case managers they have now. And I touched on that first thing earlier this afternoon. For those that are in the developmental disabilities system and they have case management through a CDDO or a CSP, they will be able to keep their case management just the same as it is now. For all the other HCBS waivers, the MCOs, the plans are ultimately responsible, either indirectly or directly to provide those services. We're in discussions with the plans now on what exactly that will look like. And there will be more information forthcoming about that. Um, but again, they are directly responsible, well, they are responsible either directly or indirectly.

Is there a website for key KanCare elements that MCOs have to follow that providers can view? I think what you're asking is can you see the RFP. And there is a link to the RFP on the KanCare website, which lays out all the conditions that the MCOs must follow.

Will billing be done online as it was before? Yes, electronic billing um, will be the way we go.

What will happen to SOBRA? No change to SOBRA. That's not part of KanCare.

Um, for a person living in assisted living facility, will the facility have to bill their services to one of these three MCOs? Uh yeah, yes. The plans will, the three plans will manage the Medicaid system in Kansas. Again, we're encouraging each of the providers to join all three plans and each of the plans to sign up all providers.

When individuals are needing state assistance, Medicaid, do they still access KDADS or what's the procedure? Um, if it remains the same for eligibility, in the past, individuals would contact SRS, those services, those eligibility services have remained with DCF. So, it's the Department for Children and Families. That, that portion, the eligibility portion did not come with KDADS. It's with Children and Families. That's the first access point for eligibility.

More questions about PD clients, consumers. Um, will all providers be offered the same fee schedule? Is there any negotiation? Um, good question. The floor will be the fee for service rates that are effective November 9th of this year. That's the floor, but you can always negotiate with the MCOs as well.

How will MCOs communicate with their members? Many of them don't have computers or smart phones. Good question. And the answer is in person, by phone, despite the post office's inability to pay their loan back to the federal government, I think snail mail will still be around for a while. So, those will be the ways that they will communicate with those that don't otherwise have a computer or smart phone.

What is a health home? Health home is really quite simple. It's based around care coordination. So, as Secretary Sullivan mentioned earlier, those beneficiaries with, in the first year, have mental illness or diabetes, by the end of the first year, we want to get them into a health home so their care is being coordinated because they're seeing multiple providers. And by the end of the second year, any

beneficiary with intense needs, someone that's seeing a lot of providers, we want to get them into a health home so that their care is coordinated. Will every beneficiary be in a health home? No. But there will certainly be a number of them that are put into health homes so that their care and the needs they see many providers will be coordinated. We know how the drugs are working with one another, knowing, keeping track of their appointments and that type of thing.

Are PCPs locked in or can we see any Medicaid patient? This gets back to a primary care physician and back to we're encouraging every provider to join, to join every plan. And encouraging the plan to sign up every provider. But if you are not in a plan and you have a, a, a patient that's in a particular plan, they would be out of network.

Who is working with the current Medicaid patients to help them understand what they need to do for coverage as of January, selecting a new plan. And KDHE and KDADS, our state staff are working with patients. The MCOs will be reaching out to and holding meetings and, but primarily it's the state. It's our staff.

Will KMAP site still be up? Yes, that's another eligibility question. Yes, it will be.

KMAP eligibility? Yes.

This is a good question. This is the first time this has come up. And I laugh, though it's not funny. Um, are there plans to reduce provider rates before Nov. 9, 2012? And I told my colleagues, someone has figured out the diabolical plan. And I'm kidding. There's no plan to reduce provider rates before November 9th of this year. And again, those rates will be the floor to begin negotiations with the plans.

Will patients stop having current Kansas Medicaid cards? And will cards clearly indicate which MCO covers the patient? Very much so. The cards will come from the MCOs. Each MCO will issue a KanCare card to their patients.

An HCBS resident is admitted to a long term care facility, how does it work if the resident has selected a different MCO than the facility has an agreement with? And I understand this, but we're, bottom line, we're not going to let something like this happen. Again, we're working with the MCOs. The MCOs are working on signing each provider and we're very much encouraging the providers to join each group. So, if we do that, and all do our jobs basically the way we're supposed to, this type of situation won't happen.

Um, KMAP? Yes, KMAP.

Um, will members be able to move from MCO to MCO on a monthly basis? Um, no. once, after the initial two periods, um, so again, members, beneficiaries will get their packets in November—detailed information about each plan, and they'll be able to decide. They'll be auto enrolled in one. They'll get information about that plan. They'll get information about the other two. They can decide to opt into another plan. And yet again, from January 1 to February 14th, they will have that option. Then at that point, they're locked in for a year. It's an annual, annual you can change. (clapping) I've never gotten applause before going through any of these questions. Thank you. That makes my day. Um, inside the plan, the patients can change providers during that year.

Another KMAP question. Very popular.

Are the MCOs by region? No. Do the MCOs replace Coventry and Unicare? Yes. So, all, the three plans will handle all the state's Medicaid business. So, the plans that are currently in place go away and those services are provided by one of the three KanCare contractors.

Okay. Good, good question. And Cliff signed his name to this. Good question Cliff. Providers have been told they will not be paid rates less than current rates. The DD waiver rates are tiered one through five. Yes. Will tiered rates remain the same or will different structure be developed. And the tiered rates are going to remain the same basis is not going to go away. I don't. It's hard to say, basis is not going away. I don't see basis going away ever.

Uh, where can we get a copy of today's presentation? Very easy. You'll get it online next week.

Can HCBS providers sign up with all three MCOs? Yes. Please do.

What is the fee starting in November? The rates as of November 9, the Medicaid rates, the fee for service rates will again, the floor. Should HCBS providers sign? Yes, please sign up with all three MCOs.

I know that there are more questions and some of our other staff members want to handle these. Dave, you want to come up?

Dave Halftery—Fort Scott
I'm Dave Halftery. I work for the Department on Aging and Disability Services. And I've got some questions regarding nursing homes and long term care that I thought I'd address.

The first one is how will residents' liability amount be paid to the nursing home providers? And further, who will be able to assure the residents' liability are not withheld by a party other than the resident or nursing home? And what will, what recourse or time frame will be in place for non-collection? And then finally, how can we get a copy of the letter of understanding the state provided the MCOs regarding the determination that MCOs could not or would not be responsible for collection of the resident liabilities. So, several points on resident liability. And the bottom line is, we did discuss with the MCOs the possibility of having them collect that resident liability for nursing homes, but through that discussion, realized that probably wasn't the best plan. There were two reasons for that. One was whether or not they could take the legal role of being the payee as nursing homes currently do. And then also, whether or not that would interfere with current cash flow that nursing homes are, receive through that. Specifically, if the MCO were to collect the resident liability and then just make payments to the nursing home on a daily basis, a fee for service like they will, then that might spread out the cash flow that the resident, that the nursing home typically collects from the resident at the beginning of the month rather than getting it up front like that. So, those two concerns caused us to back away from that. And as far as doctor (inaudible) interaction, most of that was through the question, the formal questions that were asked to us and that we responded to. That's on the website as well. So, if you go to the link that Gary mentioned, to the RFP, there is also a link, a list of questions that we responded to formally.

Second question regarding nursing homes was for long term care, specifically nursing homes, what will be the fee for service rate and are we doing away with the case mix system? The answer to that is the state is going to continue to set rates for nursing homes and that rate will be the floor the MCOs will pay. So, that case mix system that we currently work off of, we'll continue to do that. We'll continue to

set rates and adjust those rates quarterly for changes in case mix and then the MCOs will pay you based on that rate or whatever you negotiate from that. That will be the floor for what they pay.

This question is cynical, sounds like the program is to shut down small nursing homes and encourage people to remain in their homes as long as possible. It's cynical, begins cynically. I say keeping people in their homes as long as possible is a positive outcome. That is one of our goals, to try and keep people independent as long as we can. It's certainly not to do away with any providers though. It's to try to provide the right services at the right time, at the right place. And we do believe, as the Secretary mentioned earlier, the opportunity for some residents in nursing homes to be served in the community. We realize a lot of times the obstacle that prevents that from happening is that there aren't services available in the community. So, we're hoping to see that change. In fact, that's been our goal for the last 15 years as we worked with our waiver programs, to try to keep more people in the community and move people to the community that could be served there. So, that continues to be a goal, maybe a more prominent, I wouldn't even say more prominent, just another feature of the KanCare program.

Final question I have is does the client have a choice in what level of care they get to use, especially long term care? And the answer to that is simple, yes. (inaudible) the case manager, care manager would work with that individual, that member and the family to try to determine what level of care, what services are most appropriate for that individual and try to meet their needs as best they can. Again, if they're able to do that in the community, they'll certainly work for that goal.

Lizz Phelps—Fort Scott
So, first one, will the services currently available through the HCBS-FE waiver be changing? And the answer is no. We don't anticipate any changes to the existing available services.

The second part says, "Please describe the care management process for waiver consumers, who will be the care manager, how will they be in contact with customers and at what frequency?" So, once a member selects one of the three KanCare plans, the plan will be responsible for connecting them to a care manager. And that will depend upon what their needs are, and so will the frequency, and so will the skill set of the care manager.

Can we get a copy of the KanCare slide presentation? And the answer is, all of the materials from these meetings will be posted on the KanCare website, both ours and the MCO presentation, so you'll have access to that, including that information that relates to the value added services.

Some of these are a little bit duplicated. When we get back in that room with all these cards, it looks like a game of Twister. "I'll take that one." So, there's a little bit of (inaudible) here.

What agency/company will manage the HCBS SET waiver now managed through KHS and KDADS? So, the short of that, as is with all of our waiver programs, is that the KanCare plans will have primary responsibility for managing the program, but the state will continue to have policy setting and monitoring oversight for the programs. So it will be the KanCare plans and KDADS.

Um, what agency will conduct CMHC licensing visits? So, the state will never give up the um, licensing responsibility to a contractor. We may be collaborating with them on information about providers' performance and licensing.

This is kind of a (inaudible) question. What will happen to individuals with disabilities if the providers aren't meeting outcomes as determined by the MCOs? So, ultimately the MCOs are going to be responsible to ensure that each member's needs are met and each of the contracting outcomes are achieved. And so if that's not happening, they will be stepping in either directly or at our request to get corrective actions taken care of and to ensure that the member's needs get met. There might have been more to that question, so if it's yours, talks to me after I'll be happy to (inaudible).

Kelley Melton–Overland Park
…consumers like it is now? Um, yes we will. The MCOs have been required to follow our $3.40 dispensing fee per claim, so they will pay that to providers for each pharmacy claim they dispense. And another question that was kind of a follow up to that, someone asked if that will be a client obligation in the form of a co-pay. And as I said, no, the $3.40 dispensing fee will go to the MCOs from a pharmacy provider and there's actually no co-pays on pharmacy claims for beneficiaries.

Alright, another question. Under the pharmacy management services, will there be concessions for facilities so that meds can be bubble-packed, non-mail order and on the ability to get stat meds, not only for SNFs but for ACFs. And this is true as well. We had some conversations with um, pharmacies that provide medications to these kinds of facilities. And provided that they sign up with the managed care organizations as well, you will be able to continue to use your customary pharmacy to provide meds to those facilities, because we recognize that um, you know, stat medications that's a need for which you need to be able to have an immediate response from an established pharmacy that, that you've worked with.

And the last pharmacy question, do pharmacies have to be contracted with each of the managed care organizations/PBMs to be able to provide meds to beneficiaries? And we are strongly encouraging each of our pharmacy providers to contract with all three of the MCOs in their PBMs, so that they will be able to provide medication services to any KanCare beneficiary. So, it's not a requirement that you contract with all three, but um, in order to meet the needs of any of your current Medicaid beneficiaries, it would be in your best interest.

See me afterwards if you have any follow up pharmacy questions.

Sec. Shawn Sullivan—Overland Park
Alright, I have a stack to go through, so I'm going to try to do this as quickly as possible. And if I don't get to your question, they will be on the internet, the KDHE website. Some of them we're not going to answer because they're more personal in nature and it's more appropriate to ask us afterwards. And some of them we need to track down and clarify the answer. But we'll try to go through as many as possible.

Will our rates still be figured, and this is a nursing home question, will our rates still be figured by the same process, it's a quarterly case mix. Yes, that will still be done. And it will still be done by the state, or particularly for Aging and Disability Services.

Will the state continue to set the room and board rates for nursing homes? Yes.

Are hospice services part of KanCare? Yes they are.

For nursing homes, current rate changes quarterly set by state? Yes. That will not change.

Will nursing homes still be able to bill directly or KMAP? The answer is yes. We are working on a central billing portal for all providers. I need to get my eye checks.

If we're currently, if I'm currently a Kansas Medicaid provider, will I be contacted by the three MCOs to apply automatically? As you heard during the presentations, yes. But if you don't hear from them, please do contact them to get your name on their list.

Will they use CAQH, which I believe is a credentialing tool. If you are using CAQH, that answer is yes. We are also working, as already been mentioned a couple of times, at the state level to quickly get done a standardized credentialing packet contract to them that they will then send to you.

Okay, someone asked or said that I stated the SED waiver be part of the options counseling and on and on. Um, that is not the case. SED waiver is not the three, one of the three populations. That will be done by the ADRCs for the assessment options counseling. That is the frail elderly, nursing homes, physically disabled and traumatic brain injury.

Is the KBH, which I believe is the KanBee Health exam, still being offered? Yes. Same criteria, not going to change.

Uh, will AuthentiCare continue to be used for reimbursement for MCOs, specifically that is for FMS self-directed clients? And that answer is yes.

Question, will there still be HealthWave? There will still be HealthWave-type services, but HealthWave will no longer be called HealthWave. It will be called KanCare with the three current contractors, or three contractors we're using.

What will the financial eligibility look like for Medicaid and/or HealthWave? The answer is, that is not changing. Although, as you may have read or heard, the state is working and contracting with Accenture on what is called KEYS, a streamlined eligibility system that should be implemented next year.

How will the state police the actions of the managed care organizations? (laughing) I have a big badge. Um, really if you want to find out more on that, refer you to section J, the state quality strategy of the RFP of the contract. That's on the state website, for more information.

Will patients need a referral from their case manager/care coordinator to see a specialist? Question here is an example of an eye doctor. That question in this specific case is no.

How will these changes affect durable medical equipment providers, will they still be paid 100 percent? That answer is, yes they will be. Current rates are not changing, will continue the same.

If a doctor, is a physician is a non-contracted provider and is paid the out of network rate, a fee for service rate of 90 percent, can he/she balance bill? That question, answer is no.

Who will do the options counseling for those not working with an ADRC? For HealthWave consumers, it will be somewhat how it is now, with a hotline, a beneficiary hotline. For mental health, it will be through help with their case managers, TCMs, community mental health centers. Same for CDOs. For the IDD waiver, when they are rolled in for their waiver services.

Will the managed care organizations be passing the three to five percent withhold on the pay for performance measures onto providers? That is a no.

Uh, several questions, as we would expect, that related to how targeted case management will work. So, here's my explanation on that. So, you have a couple different systems. You have the intellectual/developmentally disabled waiver, which as we, as I described, will have some services rolled out in January of 13 and the waiver services implemented one year after in January of 14. Um, because of the DD Reform Act from 17 years ago, the CDDOs will continue to provide duty assessments and either themselves or by affiliate, perform the TCM services and then also services. That will absolutely not change. For some of the other systems, um, that still get to be determined on how exactly HCBS TCM is going to work. As some of the representatives from the three companies got up and said to you, uh, we are, as a state, are still working with them on a lot of those operational details. What is in the contract, except for IDD, is that they will provide TCM services directly or indirectly, which means by themselves or subcontractor providers. Um, more clarification, guidance will be coming on that in the next probably two weeks.

Uh, other questions on case management that are more specific. What will be the implementation date for agencies that provide both case management and services, or FMS, for the same individual? To separate those, that will be January 13 implementation.

Does the state have plans to publish an RFP for FMS to lower the number of FMS providers? Um, we have a work group of probably 10 or 12 different providers that have been formed and met two or three times. There's nothing impending, no decisions have been made. The work group has formed to help the state with recommendations on the best way to move FMS system and self-direction in a whole, moving forward.

Uh, can an FMS provider give FMS or HCBS provider give FMS services and targeted case management services for a PD waiver consumer at the same time? Um, again, an organization will be, with what we have, which is a CMS definition of case management or conflict free case management, will be able to provide both services but not to the same person.

What factors were considered when choosing the three managed care entities? Um, we took some darts (laughing). We had probably 100, I don't know 25, 50 staff between multiple agencies that had a very comprehensive review process over several months. Generally with state contracts, and how we did it with this, the technical aspects of the bids were evaluated and then scored. And then following that, the financial aspects of the bids are unsealed and evaluated…

…yes you will. How long are the contracts? What are the chances in years two or three the managed care organizations will significantly reduce the payments? Um, so that is to address the requirement that the three contracts or companies be offered providers, current providers a place under network contract at or above the current fee for service floor. That is for the life of the contract. the contract structured is for a three year contract with two additional one-year opt ins. Uh, oh, so it's essentially a three-year contract, probably five, so the reimbursement floors are locked in as long as, during the course of that contract. What happens after that would be up to negotiation following that five years or whoever's the decision makers at that time.

What type of KanCare materials have been distributed to HealthWave recipients? That is all coming in the next couple of weeks and months. We're of course having these forums, but with all Medicaid persons we serve, we have a member, one of our four implementation work groups is related to member education and they are helping us with a plan in addition to these four rounds of educational tours we are doing written materials, just the best way to get the word out. So, that will be coming.

Great question. Not that they're not all great. But, will the value added services for the ABD population be available to persons on the IDD waiver, even though the IDD waiver has been carved out for one year? So, um, the value added services that are offered, that are physical, behavioral health-related, yes will be included as services, value added services even for the 8,500 that are on the IDD waiver. We have a, for other services that may or may not be included an intellectual/developmentally disabled pilot work group that's currently meeting, or met in July and that forwarded on recommendations to us to forward on Requests for Information that will be going out soon to further engage stakeholders to what the pilot programs will look like. And then following that process, we will put out information on how current IDD providers can apply to be pilot sites within KanCare, starting January of 13. That will be a voluntary process and should an organization, provider, CDDO or community service provider choose to want to be a pilot site, starting in January, even with that, the persons they serve would be enrolled voluntarily, they would not be mandatory. So, that work group has worked with us on some recommendations on what would be good value added services for those pilot sites. Nothing has been finalized. We are also working with the managed care entities on that as well. So, more information will be forthcoming.

What are the steps to becoming an ADRC? Can an agency which has provided HCBS services become an ADRC? The state let an ADRC contract or RFP, Request for Proposal in March. We're currently in the procurement process for that and should be probably in the next month announcing who the, when we get through final negotiations and procurement process, announcing who will be an ADRC. We will be contracting with one entity. We left it through the RFP that the ADRC's bidding would tell us how they're going to make that real-type approach. So, it somewhat depends on how the procurement process turns out.

Currently as a state facility, patients ages 21 to 64 are not entitled to Medicaid benefits, will this change with managed care? The populations served are not changing. That will not change with KanCare.

And then, how will this affect the HCBS waiting list? So, there's a waiting list for both IDD and the physically disabled waiver. Um, we are hoping through the 1115 to offer some pilots for both waiting lists…the 1115 on how that will look and when it will be rolled out. KanCare services, medical services will be offered to those that are on the PD or the IDD wait lists. Um, so, that's kind of the immediate answer. Kind of the more long term answer that people ask is will this allow the state to reduce or eliminate the waiting lists? My answer to that is, our current old Medicaid system makes it very, very hard when you're already spending 7.5 percent every single year more on Medicaid as a whole to appropriate more than that on programs to reduce the waiting lists. Our belief is that KanCare gives us more funds globally for the state to use to apply to Medicaid, including waiting lists, so.

With that, I think we will wrap up. There are a couple more questions that we need to clarify, couple more questions that had more personal situations attached to them. Again, you can look at the state website next week and see the exact responses. So, anything else, are we? Alright. Thank you all for your attention this afternoon. And we wills stick around following this, as will the managed care organizations, so if you have any questions you would like to ask.